Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
FACILITY INSURANCE CORP

MFDR Tracking Number
M4-17-1691-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was [Claimant's] first psychological interview for this work related injury. Therefore, preauthorization was not required."

Amount in Dispute: $900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier position that the psych eval billed on 3-16-2016 required preauthorization. We are attaching regarding this claimant the 9-13-1995 psych eval request…it is certainly a repeat evaluation given what has gone before."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2016	CPT Code 90791 (X3) Psychiatric Diagnostic Evaluation	$900.00	$206.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Precerfitican/authorization/notification absent.
   - 240-Preauthorization not obtained.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the disputed CPT code 90791 require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed psychiatric interview, code 90801, based upon "197-Precertification/Authorization/Notification absent."

   28 Texas Administrative Code §134.600(p)(7) states, "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program."

   The respondent states in the position summary that "It is the carrier position that the psych eval billed on 3-16-2016 required preauthorization. We are attaching regarding this claimant the 9-13-1995 psych eval request…it is certainly a repeat evaluation given what has gone before."

   The requestor contends that preauthorization is not required because "This was [Claimant's] first psychological interview for this work related injury."

   Review of the submitted documentation finds that the respondent did not submit documentation to support that the disputed service was a repeat psychological evaluation; therefore, the preauthorization denial is not supported. As a result, reimbursement is recommended.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

   A review of the submitted billing and medical records finds that the requestor billed for three units of code 90791.

   CPT code 90791 is not defined as a timed procedure; therefore, the service is considered per session and only one unit should be billed. Based on the code descriptor and the submitted report, one unit is recommended for reimbursement.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2016 DWC conversion factor for this service 56.82.

   The Medicare Conversion Factor is 35.8043.

   The Medicare participating amount is $130.08.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78411, which is located in Corpus Christi, Texas.

Using the above formula, the Division finds the MAR is $206.43. The respondent paid $0.00. As a result, the requestor is entitled to reimbursement of $206.43.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $206.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

Authorized Signature

		03/02/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.